The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 authorized several technical corrections to section 1937 of the Social Security Act, which allows States to establish alternative benefit plans. One of the CHIPRA technical corrections requires CMS to post on the Internet the State plans approved by the Secretary under section 1937 authority.

Described below are the benchmark/benchmark-equivalent State plans approved by the Secretary since passage of the Deficit Reduction Act of 2005, which created benchmark plans authority under section 1937 of the Social Security Act. Under section 1937, States are permitted to provide coverage to Medicaid eligibles without regard to provisions/requirements which normally apply to State plan services such as statewideness (1902)(a)(1)), comparability (1902)(a)(10)(B) and freedom of choice of provider (1902)(a)(23). Therefore, it is to be noted in the descriptions below that many benchmark/benchmark-equivalent benefit plans exist only in certain parts of the State; that these plans provide coverage for specified populations of Medicaid eligibles; and that frequently the benefits are delivered through a managed care entity where freedom of choice is restricted.

SUMMARY OF WEST VIRGINIA'S MOUNTAIN HEALTH CHOICE BENCHMARK PROGRAM

Type of Benchmark Plan: Secretary Approved

Populations Covered by the Plan: Temporary Assistance to Needy Families (TANF) and TANF-Related Beneficiaries

Type of Enrollment: Mandatory Enrollment

Geographic Area Covered: Statewide

Type of Delivery System: Combination of managed care and fee-for-service

Summary of Benefits Provided

A basic and enhanced benefit package is available to both the healthy adults and children. Individuals may choose to enroll in the enhanced plan by signing a member agreement that focuses on access to a medical home. The benefits provided are targeted to the specific heath needs of the two groups. Individuals who do not sign a member agreement are automatically enrolled in the basic plan.

The basic benefit package provides all mandatory Medicaid services with the addition of age appropriate services that focus on wellness. The basic package for children includes: inpatient hospital services (with limitations on certain services); outpatient services (with limitations on certain services); physician services; home health (limited); durable medical equipment (limited); EPSDT services; family planning; transportation; hospice; ambulance; prescriptions (limited); vision (limited); dental (limited); hearing (limited) and tobacco cessation.

The enhanced package for children includes all of the above services without the limitations. In addition, it provides services such as weight management, podiatry, skilled nursing care and nutritional education.

The basic package for adults includes inpatient hospital services; outpatient services (with limitations on certain services); emergency dental; physician; home health (limited); durable medical equipment (limited); nursing home; family planning; transportation; hospice; emergency ambulance and prescriptions (limited).

The enhanced packed for adults include all of the above services without the limitations. It also provides services such as inpatient psychiatric services; weight management; cardiac rehabilitation; podiatry; chiropractic; tobacco cessation; diabetes care; nutritional education and chemical dependency and mental health (limited).

SUMMARY OF KENTUCY'S KyHEALTH CHOICES
BENCHMARK BENEFIT PROGRAMS

Type of Benchmark Plans:	Secretary Approved
Populations Covered by the Plan:	Global Choices – General Medicaid population including foster children and medically fragile children. All disabled and elderly populations who do not opt-in to comprehensive Choices and Optimum Choices. Family Choices – Most children including KCHIP Medicaid children Comprehensive Choices – covers individuals who meet nursing facility level of care. Individuals may be in a nursing home or in home and community based waiver for the aged and or disabled. Optimum Choices – Covers individuals with mental retardation and developmental disabilities who meet ICF/MR level of care.
Type of Enrollment:	Mandatory Enrollment into Global Choices & Family Choices; Optional enrollment for Comprehensive Choices and Optimum Choices
Geographic Area Covered:	Statewide except for sixteen counties in the Louisville region which currently operate under an 1115 waiver administered by Passport Health Plan.
Type of Delivery System:	Fee-for-service

Summary of Benefits Provided:
KyHealth Choices has four benefit plans. Members are placed in one of the following plans:

- All the benefit package plans provide all mandatory Medicaid services.
    1. Global Choices – basic Medicaid package includes: inpatient hospital; laboratory, diagnostic and radiology services; outpatient hospital/ambulatory surgical centers; physician office services, allergy services (limited to children under 21); preventive services; emergency ambulance; dental services (with limits); occupational, physical and speech therapy (no limits for children under 21, Adults 21 and older with limits); hospice (non-institutional); non-emergency transportation(with approved medical services); chiropractic services (with limits); prescription drugs (with limits and for recipients who do not have Medicare Part D); emergency room; hearing aid (limited to children under 21); audiometric services (limited to children under 21); vision services (with limits); prosthetic devices; home health services; durable medical equipment; EPSDT services(limited to children under 21) ; substance abuse (limited to EPSDT and pregnant women only); maternity services (nurse midwife, pregnancy-related services); family planning; podiatry services; end stage renal disease and transplants. Some benefit limits can be increased if the service is medically necessary (requires prior approval). The plan incorporates nominal cost sharing.
    2. Family choices – based on the Kentucky State Employee Benefit plan but includes cost sharing and limited Chiropractic services, limited Sspeech therapy, limited PT, limited OT, EPSDT services, unlimited home health and skilled nursing.
    3. Comprehensive Choices – provides lower co-pays to vulnerable populations with special needs including physician services, vision services, dental services, chiropractic services, and hearing and audiometric services.

4. Optimum choices – Provides lower co-payments to vulnerable populations with special needs including physician services, vision services, dental services, chiropractic services, and hearing and audiometric services.
5. Disease Management – provided in addition to individuals with certain diagnoses: Diabetes, COPD/Adult Asthma, Pediatric Obesity, Cardiac – Heart Failure and Pediatric Asthma. Enhanced benefits include: limited allowance for dental and vision hardware, nutritional counseling, and smoking sessation.

VIRGINIA HEALTHY RETURNS
BENCHMARK BENEFIT PROGRAM

Type of Benchmark Plan: Secretary-approved benchmark

Populations Covered by the Plan: All individuals categorically eligible in the State Medicaid plan that are determined to have asthma, congestive heart failure, coronary artery disease, and/or diabetes may elect to participate in *Healthy Returns*, with the exception of four groups of individuals. The following groups of individuals are not eligible for enrollment in Healthy Returns: individuals enrolled in Medicaid/FAMIS managed care organizations; individuals enrolled in both Medicaid and Medicare (dual eligibiles); individuals who live in institutional settings; and Individuals who have third party insurance.

Geographic Area Covered: Statewide

Type of enrollment: Voluntary

Type of Delivery System: Fee-for-service

Summary of Benefits Provided:

In addition to the traditional State plan services under Medicaid, individuals enrolled in this program will receive additional benefits tailored to specific health needs including:

- Condition specific education:
- Access to a 24 hour nurse call line (with access to other licensed Health professionals such as pharmacists and nutritionists);
- Regularly scheduled telephonic health care management and support;
- Care coordination including feedback to the primary care physician.

The disease management component is provided through a Prepaid ambulatory health plan (PAHP).

SUMMARY OF IDAHO VALUE-BASED REFORM
BENCHMARK BENEFIT PROGRAMS

Type of Benchmark Plan: Secretary Approved

Populations Covered by the Plan: Basic Benchmark Benefit Plan – healthy children and working age adults
Enhanced Benchmark Benefit Plan – individuals with disabilities and special healthcare needs
Medicare-Medicaid coordinated Benchmark Benefit Plan – elders and or individuals who are dually eligible for Medicare and Medicaid.

Type of Enrollment: Basic Benchmark Benefit Plan - Mandatory
Enhanced Benchmark Benefit Plan – Voluntary
Medicare-Medicaid Coordinated Benchmark Benefit Plan – Voluntary

Geographic Area Covered: Basic and Enhanced Benchmark Benefit Plans - Statewide
Medicare-Medicaid Coordinated Benchmark Benefit Plan – select counties

Type of Delivery System: Fee-for-service

Summary of Benefits Provided

Basic Benchmark Benefit Plan - Consists of healthy children and working-age adults.

- Provides "basic coverage" to over 80% of the Idaho Medicaid population.
- Covers most of the current Medicaid State Plan benefits with the exception of longer-term care (nursing homes, ICF-MR, and Hospice), extended mental health benefits, and organ transplants.
- Covers new benefits such as preventive services, nutritional services, and the new Preventive Health Assistance benefit.
- Includes wrap around Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) services for children.
- In accordance with section 1937 of the Act, the individuals will be mandated into the basic benefit package unless they sign a member agreement to enroll in the enhanced plan, and require medically necessary services not available through the Basic plan.
- Basic plan enrollees may enroll in the Enhanced plan if they develop a need for long-term care services.

Enhanced Benchmark Benefit Plan –

- Consists of individuals with disabilities and special health care needs
- Covers new benefits such as preventive services, nutritional services, and the new Preventive Health Assistance benefit.
- Coverage includes all Medicaid services presently offered in Idaho
- Enrollment is voluntary meaning that a beneficiary only enrolls after being informed of the alternatives and informed of his/her right to opt-out and receive traditional Medicaid State Plan service coverage at any time.
- The comprehensive benefits offered by the Enhanced plan, provides an incentive to enroll for eligible Idaho Medicaid beneficiaries.

Medicare-Medicaid coordinated Benchmark Benefit Plan –

- Consists of the dual-eligible Idaho Medicaid beneficiaries
- Coverage includes all Medicaid services presently offered in Idaho
- Enrollment is voluntary meaning that a beneficiary only enrolls after being informed of the alternatives and informed of his/her right to opt-out and receive traditional Medicaid State Plan service coverage at any time.
- Medicare beneficiaries eligible for Part B and Part D coverage of Medicare must enroll in this plan to be eligible to receive services under this plan.

WASHINGTON CHRONIC CARE MANAGEMENT
BENCHMARK BENEFIT PROGRAM

Type of Benchmark Plan: Secretary approved

Populations Covered by the Plan: All categorically needy aged, blind or disabled adults aged 21 or over with complex medical needs who are diagnosed with chronic medical conditions including: diabetes, heart failure, coronary artery disease, ceeerebrovascular disease, renal failure, and chronic pain associated with musculoskeletal conditions or other chronic illness.

Type of Enrollment: Voluntary

Geographic Area Covered: Statewide

Type of Delivery System: Fee-for-service

Summary of Benefits Provided:

In addition to the traditional State plan services, individuals enrolled in this program will receive additional benefits tailored to specific health needs, including:

- Condition-specific education;
- Access to a nurse call line;
- Regularly scheduled telephonic health care management and
- support;
- Care coordination including feedback to the primary care
- physician.

SUMMARY OF WISCONSIN'S BADGERCARE PLUS
BENCHMARK BENEFIT PLAN

Type of Benchmark Plan: Equivalent to Coverage offered through the State's largest HMO, United Health Care Choice plus Plan.

Populations Covered by the Plan: Pregnant women and infants with incomes between 200% and 250% FPL. Newborns deemed eligible and are born to women with family incomes between 200% and 250% FPL.

Type of Enrollment: Mandatory

Geographic area of the State: Statewide

Type of delivery system: Managed care, fee-for-service, primary care case management.

Summary of the benefits provided

The BadgerCare Plus benchmark plan covers chiropractic services, dental services, disposable medical supplies, durable medical equipment, emergency room, family planning services, healt screenings for children, home care services (home health, private duty nursing and personal care), hospice care, inpatient hospital services, mental health and substance abuse services, nursing home services, occupational therapy, outpatient hospital services, physical therapy, physicians visits (including laboratory and radiology), podiatry services, prescription drugs, smoking cessation services, speech therapy, transportation, and vision services. Some services require a copayment.

SUMMARY OF KANSAS' WORK BENCHMARK BENEFIT PROGRAM

Type of Benchmark Plan: Secretary Approved

Populations Covered by the Plan: TWWIIA Basic 1902(a)(10)(A)(ii)(XV), *Working Healthy*, State Medicaid Buy-in Program

Type of Enrollment: Voluntary Enrollment

Geographic Area Covered: Statewide

Type of Delivery System: Fee-Ffor-service with the option to self-direct and use the cash and counseling model.

Summary of Benefits Provided

In addition to the traditional State plan services, individuals enrolled in this program will receive additional benefits tailored to specific health needs including:

- Person-centered assessments;
- Personal Assistance Services such as assistance with ADLs, IADLs, and health-maintenance activities that are permitted under State law;
- Independent Living Counseling such as information, training and assistance necessary for individuals to direct and manage their personal assistance and related services and service budgets;
- Assistive Services such as items or equipment that will improve independence, employment and/or health and safety.

Individuals decide whether they want to self-direct or have an agency direct their care, determine whether to use the services of an Independent Living Counselor or manage their care independently, decide whether to use a fiscal management services or act as their own fiscal manager (Cash and Counseling), and choose providers with whom they feel the

most comfortable rather than have to use mandated providers based on their disability or geographical location.

SUMMARY OF MISSOURI'S "INSURE MISSOURI"
BENCHMARK BENEFIT PROGRAM – (Not Implemented)

Type of Benchmark Plan:

Benchmark Equivalent Benefits equivalent to FEHBP Blue Cross/Blue Shield Standard Option PPO

Populations Covered by the Plan:

Parents and Specified Caretaker Relatives age 19 and over eligible under Section 1931 through a disregard of additional income up to 100% FPL (never implemented)

Type of Enrollment:

Mandatory Enrollment

Geographic Area Covered:

Statewide

Type of Delivery System:

Combination - The Insure Missouri program was to be a public/private partnership and as such private insurers would have been responsible for delivering the covered services. The State had intended to issue a Request for Proposal for potential insurers and intended to accept bids from the insurers proposing the full range of delivery system models, including health maintenance organizations, preferred provider organizations and indemnity plans.

Summary of Benefits Provided:

For the Insure Missouri benefit package, the state had intended to contract with health carriers on a per member per month at risk basis for the following services:

1. Inpatient hospital
2. Outpatient hospital and ambulatory surgical center services
3. Physician and advanced practice nurse services
4. Federally Qualified Health Center (FQHC) services
5. Emergency care services
6. Laboratory, radiology, and other diagnostic services
7. Prescription drugs
8. Mental health and substance abuse treatment
9. Home health services
10. Durable medical equipment (including, but not limited to: orthotic and prosthetic devices, respiratory equipment and oxygen, enteral and parenteral nutrition, wheelchairs and walkers, and diabetic supplies and equipment)
11. Family planning services
12. Personal care services
13. Emergency transportation (ground and air) services
14. Hospice services
15. Services provided by local public health agencies:
. Sexually transmitted disease (STD) services
. HIV services
. Tuberculosis services
16. Transplant related services

Additional Benefits:
1. Abortion Services as required by Federal law
2. Solid organ and bone marrow/stem cell transplant services

Additional Benefits:
1. Home Health
2. Hospice

The state intended to provide fee-for-service coverage as required by the approved Medicaid State Plan for those days after a participant becomes eligible until the participant is enrolled with the health carrier and for any retroactive period of eligibility as additional coverage.